



Swindon Advocacy Movement
 Swindon Advice and Support Centre
 Sanford House
 Sanford Street
 Swindon
 SN1 1QH
 Telephone on 01793 542575/616562
 Fax Number 01793 423124

REFERRAL FORM

Client Details					
Name:					
Date of Birth:					
Address:	Accommodation Type:				
	Home Owner				
	Living with Family				
	Social Housing Tenant/Council House				
	Private Tenant				
	Supported Housing				
	Hostel				
	Hospital				
Other					
G P Name:					Current location of client (if not at home address)
Address:					
Telephone Number:					
Children under 18:	Yes: Number:		No:		
Carer:	Yes:	No:	Do they have a Family Carer:	Yes:	No:
Personal Budget:	Yes:	No:	In Receipt of Benefits	Yes:	No:
Referred By:			Position:		
Telephone Number:			Email:		
Agency:					
Other People involved in clients life:					
What is the best way for us to contact the client?					
Has this person agreed for this referral to be made				Yes:	No:

Please tick which service you would like to make a referral for:			
Section A - Statutory Advocacy Section B - Non-Statutory Advocacy			
A. Statutory Advocacy under the Care Act 2014 <input type="checkbox"/>			
Must meet the following criteria – please tick one of the following			
Adults who need care and support	<input type="checkbox"/>	Carers of Adults (including young carers)	<input type="checkbox"/>
Carers of children in transition	<input type="checkbox"/>	Children who are approaching the transition to Adult services	<input type="checkbox"/>
Undergoing the following – please tick which applies			
Care Assessments	<input type="checkbox"/>	Care and Support Planning	<input type="checkbox"/>
Care and Support Reviews	<input type="checkbox"/>	A Safeguarding Enquiry	<input type="checkbox"/>
A Safeguarding Adult Review	<input type="checkbox"/>		<input type="checkbox"/>
What is the nature of the client’s substantial difficulty please tick which applies?			
Communicating their views wishes or feelings?	<input type="checkbox"/>	Retaining information?	<input type="checkbox"/>
Using or weighing up information?	<input type="checkbox"/>	Understanding relevant information?	<input type="checkbox"/>
Please detail any other information regarding the persons difficulty in being fully involved within the processes:			
Are there any family or friends who can act as an appropriate person?			
Or is there a disagreement between the LA and appropriate person, and they both agree an advocate would be beneficial? Yes/No			
Or is an appeal against the LA decision being made? Yes/No			
Is a placement being considered in NHS funded provision in a hospital (4 weeks +) or a Care Home (8 weeks +) Yes/No			
B. Non-Statutory Advocacy – Please see further details on our Website regarding our Services. www.swindonadvocacy.org.uk			
Parents with Learning Disabilities Advocacy			
One to One Advocacy Adults with Learning Disabilities			
High Functioning Autism Aspergers’s Advocacy			
Buddies Project Adults with Learning Disabilities			
Please give details of advocacy need:			

Risk Assessment:
This section needs to be completed in order for us to provide a service to the client. Please indicate below anything in the client's history or health needs which may give rise to potential risks or dangers either to themselves or to others. Please be aware, advocates are lone workers who often visit clients at home.
Any known mental health issues:
Any behaviours we need to know about:
Any known risks in lone working/visiting at home i.e. friends, family, history etc:
Any particular health needs i.e. Epilepsy, Asthma etc:
Any particular communication needs:
Any other details we need to be aware of:

In accordance with the Data Protection Act 1998, all information provided on the referral form and in any further dealings with Swindon Advocacy Movement will be treated as confidential and will not be disclosed to any third party without express consent from the client.

Please tick here if you would like to go on our mailing list for AGM etc

Signed (Client) _____ Date _____

Signed (Referrer) _____ Date _____

"Swindon Advocacy Movement is committed to safeguarding and promoting the welfare of children, young people and adults. Swindon Advocacy Movement expects all staff and volunteers to share that commitment"

Please send the above referral to:

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SN1 1QH**

**Telephone Number 01793 542575/616562, Fax 01793 423124
Email: info@swindonadvocacy.org.uk (please send password protected)**



Swindon Advocacy Movement
April 2016 – March 2019

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EQUAL OPPORTUNITY MONITORING FORM

Swindon Advocacy Movement is committed to managing diversity and ensuring equality of opportunity for all. We will treat all cases fairly and equally in all aspects of their race, disability, gender, age, religion or belief, sexual orientation, marital status, pregnancy, maternity and sex.

In order to ensure the continued development of our Equal Opportunities and Diversity Policy all Clients are asked to complete the details below. The information will be used solely for monitoring purposes and will be treated as confidential.

Client Details							
I am:	Married	Single	Divorced/ Separated	Widowed	Prefer not to say		
My Gender Is:	Male	Female	Transgender		Prefer not to say		
Sexuality:	Heterosexual	Homosexual	Lesbian	Bisexual	Prefer not to say		
My Religion is:	Christian	Muslim	None		Prefer not to say		
	Sikh	Hindu	Other (please state)				
Employment Status:	Employed	Unemployed	Registered Disabled	Retired			
Age Groups	16-24	25-34	35-44	45-54	55-64	65+	Prefer not to say
I am	Pregnant	Or Maternity	Prefer not to say		Not applicable		
Post Code:							
Ethnicity:							
White British			Asian – British or Indian				
White Irish			Asian – British or Pakistani				
White Other			Asian – British or Bangladeshi				
Please specify;			Any other Asian background				
Mixed – White & Black Caribbean			Black – British or Black Caribbean				
Mixed – White & Black African			Black – British or Black African				
Mixed – White & Asian			Other Black				
Mixed – White Other			Oriental - Chinese				
Any other mixed background			Oriental – Other				
			Not Established				
Disability:							
Do you consider yourself to have any long-standing illness or disability that affects your daily activities or the work that you do? Please tick							
Yes		No		Prefer not to say			
If you have answered yes to the question above, how would you best describe your disability. Please tick all that apply							
Hearing		Speech		Physical		Mental Health	
Visual		Mobility		Learning		Other	